



Enrollment Worker Training

California Department of Public Health
Office of AIDS (OA)





Learning Objectives

- **By the end of this course you will...**
 - ...know the basics of OA-HIPP
 - ...understand the eligibility criteria
 - ...be able to complete the appropriate forms
 - ...be familiar with enrollment incentives
 - ...learn how to become a new enrollment site
 - ...be certified as an OA-HIPP Enrollment Worker





Our Path Today

1. OA-HIPP 101
2. Application Processing
3. Enrollment





What Is OA-HIPP?





What Is OA-HIPP?

- Formerly known as CARE/HIPP
- ***Premium payment program*** for people who have comprehensive health insurance coverage that includes a prescription drug benefit.
- OA also pays drug co-pays and deductible for individuals also enrolled in ADAP





What Is OA-HIPP?

- For people who are about to *lose* or *cannot afford* to pay for their **COBRA** coverage
- Also for people who don't have insurance but acquire a quote
- Payments are made *directly* to the insurance company each quarter
- Eligibility requirements have been *expanded* to allow more people on the program





Eligibility Requirements

- Must be a ***California resident***
- Client ***cannot*** be enrolled in Medi-Cal or Medicare
- Must have an HIV or AIDS diagnosis
 - ***No longer have to be disabled***
- Individuals without insurance may apply
- Individuals with employer paid insurance are not eligible





Eligibility Requirements

- **AGI must not exceed \$50,000**
 - **No** Asset limit
 - Must include tax return **or** all sources of income
 - Must include **spouse's or domestic partner's** income if client's income exceeds \$50,000
 - Consider 50% of combined spouse's and individual's income when assessing income eligibility





Eligibility Requirements

For clients *with* insurance

- **Monthly premium limits for OA-HIPP:**
 - Non-ADAP Clients: \$1,337
 - ADAP Clients: \$1,938
- **Partial payment of OA-HIPP premiums**
 - Clients can pay the balance of premiums that exceed the program limits



Eligibility Requirements

For clients ***without*** insurance for 6 or more months but ***with*** an insurance quote

- Consider ***PCIP*** eligibility
- **Monthly premium limits for OA-PCIP:**
 - Non-ADAP Clients: Actual monthly PCIP premium (based upon their age and location)
 - ADAP Clients: Actual monthly PCIP premium (based upon their age and location) plus \$424



Eligibility Requirements

- Clients can remain on the program as long as the services are needed ***and*** they continue to meet all eligibility requirements





Recertification

- Re-certification *or* re-enrollment ***required*** every ***six*** months after initial “syncing” of cycle





Syncing Recertification

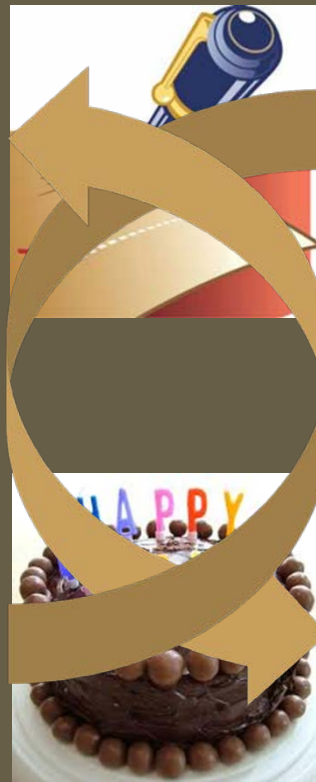
- ***When*** re-certification/re-enrollment cycle ***starts*** depends upon:
 1. Month client originally enrolled
 2. Client's birthday month





Goal

- Re-enroll *during* birthdate month
- Re-certify six months *after* birthdate month





Birthday Month Matters



- Cycle **1**
 - Initially enroll *during birthday month*
- Cycle **2**
 - Birthday month occurs **2 to 6** months *after* initial enrollment
- Cycle **3**
 - Birthday month occurs **7 to 12** months *after* initial enrollment



Cycle 1

- Client enrolls during birthday month
 - Re-*certify* six months *after* each birthday
 - Re-*enroll* during every *birthday month*





Cycle 1 Example

Initial Enrollment Month *January*

Birthday Month *January*

Re-Certification *July*

Re-Enrollment *January*

Re-Certification *July*

Re-Enrollment *January*

Etc. Etc. Etc.





Cycle 2

- If birthday month occurs 2 – 6 months *following* initial enrollment
 - **First** re-certification during next birthday month
 - Re-certify six months following every birthday month
 - Re-enroll during the second birthday month following initial enrollment and every birthday month thereafter





Cycle 2 Example

Initial Enrollment Month *January*

Birthday Month *April*





Cycle 3

- If birthday month occurs 7 to 12 months *following* initial enrollment
 - Re-enroll during every birthday month
 - Re-certify six months after each birthday
 - *Similar* to Cycle 1 but...





Cycle 3 Example

Initial Enrollment Month *January*

Birthday Month *September*



Questions





Introduction to OA-HIPP

- What is OA-HIPP?
- Eligibility Requirements
- Application Requirements
- Forms



Application Requirements

- Clients already enrolled in ADAP will be required to submit ***fewer*** forms
- Recertification will require ***fewer*** forms than initial enrollment and annual re-enrollment
- ***All*** supporting documentation ***must*** be included to process application





Checklist

OA-HIPP CHECKLIST

The Office of AIDS Health Insurance Premium Payment (OA-HIPP) program will pay private health insurance premiums for individuals that meet the following requirements:

- Must be a California resident;
- Must be at least 18 years old;
- Must have an HIV/AIDS diagnosis;
- Must have an income not to exceed \$50,000; and
- Must not be enrolled in Medicare or Medi-Cal.

If you meet the program requirements and would like to enroll in OA-HIPP, please complete the following forms that apply completely and accurately. Applications will not be processed until all forms and documentation are provided.

Determine ADAP co-enrollment status	With ADAP		Without ADAP	
Determine if this is the OA-HIPP initial/annual enrollment or recertification	Enroll	Recert	Enroll	Recert
1. OA-HIPP Application	x	x	x	x
ID Verification, submit a copy of one of the following: Driver's License, State ID, School ID, Military ID, Passport, Permanent Residence Card, Work Permit, Photo identification document issued by a foreign government, or Immigration Card. If no other form of photo ID - Birth Certificate or letter from the treating clinician certifying identity.			x	
California Residency Verification, submit a copy of one of the following: Utility Bill (electricity, water, gas, cable), Lease Agreement, Rent Receipt, Mortgage Statement, Voter's Registration, Vehicle Registration, W-2, 1099 Tax Form, or Support Verification Affidavit			x	
Health Insurance Verification: Insurance Estimate Letter, or Billing Statement (which includes Payee name, Federal Tax ID Number, premium payment address, monthly insurance premium, and effective dates), and documentation confirming prescription drug coverage (one-time) (If dental and vision coverage is through a different payee submit another OA-HIPP application to include dental and vision payee information)	x	x	x	x
HIV/AIDS Diagnosis Verification, submit one of the following: Lab results with HIV/AIDS Diagnosis, Diagnosis Form, or a clinic specific letter of diagnosis			x	
Income Verification, submit the Financial Eligibility Form and the following income documentation that apply: California State tax Return, Federal Income Tax return, W-2 or 1099 tax form, Pay Stub (3 current consecutive months), Bank Statement (3 current consecutive months that must clearly state income source), Benefit Receipt or Check Stub, Disability Award letter, Support Affidavit, or Self-Employment Affidavit			x	
Public Assistance Screening Form and supporting documentation			x	
2. Insurance Assistance Section Consent Form	x		x	
3. Client Report Form	x		x	

Please submit the completed forms and supporting documentation to:

Insurance Assistance Section
California Department of Public Health
P.O. Box 997426, MS 7704
Sacramento, 95899-7426

Or fax to (916) 449-5860



Checklist

- *Summarizes* all program requirements:



The Office of AIDS Health Insurance Premium Payment (OA-HIPP) program will pay private health insurance premiums for individuals that meet the following requirements:


- Must be a California resident;
- Must be at least 18 years old;
- Must have an HIV/AIDS diagnosis;
- Must have an income not to exceed \$50,000; and
- Must not be enrolled in Medicare or Medi-Cal.

If you meet the program requirements and would like to enroll in OA-HIPP, please complete the following forms that apply completely and accurately. Applications will not be processed until all forms and documentation are provided.



Checklist

- Gives examples of types of supplemental documentation that can be submitted to fulfill program requirements



Determine ADAP co-enrollment status	With ADAP		Without ADAP	
Determine if this is the OA-HIPP initial/annual enrollment or recertification	Enroll	Recert	Enroll	Recert
1. OA-HIPP Application	x	x	x	x
ID Verification, submit a copy of one of the following: Driver's License, State ID, School ID, Military ID, Passport, Permanent Residence Card, Work Permit, Photo identification document issued by a foreign government, or Immigration Card. If no other form of photo ID - Birth Certificate or letter from the treating clinician certifying identity.			x	
California Residency Verification, submit a copy of one of the following: Utility Bill (electricity, water, gas, cable), Lease Agreement, Rent Receipt, Mortgage Statement, Voter's Registration, Vehicle Registration, W-2, 1099 Tax Form, or Support Verification Affidavit			x	
Health Insurance Verification: Insurance Estimate Letter, or Billing Statement (which includes Payee name, Federal Tax ID Number, premium payment address, monthly insurance premium, and effective dates), and documentation confirming prescription drug coverage (one-time) (If dental and vision coverage is through a different payee submit another OA-HIPP application to include dental and vision payee information)	x	x	x	x
HIV/AIDS Diagnosis Verification, submit one of the following: Lab results with HIV/AIDS Diagnosis, Diagnosis Form, or a clinic specific letter of diagnosis			x	
Income Verification, submit the Financial Eligibility Form and the following income documentation that apply: California State tax Return, Federal Income Tax return, W-2 or 1099 tax form, Pay Stub (3 current consecutive months), Bank Statement (3 current consecutive months that must clearly state income source), Benefit Receipt or Check Stub, Disability Award letter, Support Affidavit, or Self-Employment Affidavit			x	
Public Assistance Screening Form and supporting documentation			x	
2. Insurance Assistance Section Consent Form	x		x	
3. Client Report Form	x		x	

- ***Not meant to be exhaustive, please refer to guidelines***
 - Other forms of documentation not listed may suffice to meet program requirements



Introduction to OA-HIPP

- What is OA-HIPP?
- Eligibility Requirements
- Application Requirements
- Forms



Forms

1. Program Application
2. Diagnosis Form
3. Financial Eligibility Form
4. Support Verification Affidavit
5. Self-Employment Affidavit
6. Public Assistance Screening Form
7. Insurance Assistance Consent Form
8. Client Report Form





1. Program Application

State of California - Health and Human Services Agency		California Department of Public Health		
OA-HIPP PROGRAM APPLICATION				
Are you currently enrolled in the AIDS Drug Assistance Program (ADAP)? <input type="checkbox"/> YES <input type="checkbox"/> NO Did you know ADAP pays prescription deductibles and co-payments to eligible recipients for drugs on the ADAP formulary? We encourage you to apply, for more information call (888) 311-7632.				
I. Applicant Information				
Applicant's Name (First, MI, Last)		Social Security Number	Mother's Maiden Name	
Home Address (Number, Street, Apt #)	City	County	State	Zip Code
Mailing Address (if different than home)	City	County	State	Zip Code
Telephone Number (Home)	Telephone Number (Alternate)		Date of Birth (mm/dd/yyyy) / /	
II. Current Insurance Plan Information (Please attach a copy of your member ID card and a billing statement)				
Does the applicant currently have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, number of months without health insurance? _____				
Is the applicant a citizen or legal resident of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Plan Name (See member ID card)		Member ID Number	Policy Number	
Payee Name	Premium Amount \$ Monthly		Payee's Federal Tax ID Number	
Payee Address (Number, Street, or P.O. Box)	City	State	Zip Code	
IMPORTANT: Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS). The information may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.				
AUTHORIZATION TO OBTAIN INFORMATION: Pursuant to Civil Code Section 1798.24(b), I authorize the release of information to the CDPH with regards to health insurance premiums and benefits including prescription records relating to alcohol, drug abuse, psychiatric treatment, and HIV test results or treatment. I authorize payment of refunds to CDPH for premiums paid by OA's health insurance assistance program. This authorization is valid for two years from the date signed.				
DECLARATION: I agree to re-enroll annually and re-certify as required by the OA-HIPP Program. I agree to inform OA of any changes to my health insurance premiums or eligibility requirements for the program as soon as I am aware of these changes. I certify that the answers I have given in this application and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance.				
Signature of Applicant		Date		
Signature of Policy holder (if different)		Date		
STATE OF CALIFORNIA USE ONLY - AUTHORIZATION TO PAY PREMIUM				
Monthly premium Amount \$ x Months = Total Paid \$		Effective Date to	OA-HIPP Liaison	
The CDPH Insurance Assistance Section authorizes the above payment(s) in the amount, and to payee indicated above.				
Authorized Signature		Date		



1. Program Application

Basic Client information

- Name, Address, SSN etc.

Current Health information

- Provider, ID, etc.

OA-HIPP PROGRAM APPLICATION

Are you currently enrolled in the AIDS Drug Assistance Program (ADAP)? ☐ YES ☐ NO
Did you know ADAP pays prescription deductibles and co-payments to eligible recipients for drugs on the ADAP formulary?
We encourage you to apply, for more information call (888) 311-7632.

I. Applicant Information

Applicant's Name (First, MI, Last)		Social Security Number		Mother's Maiden Name	
Home Address (Number, Street, Apt #)	City	County	State	Zip Code	
Mailing Address (if different than home)	City	County	State	Zip Code	
Telephone Number (Home)	Telephone Number (Alternate)		Date of Birth (mm/dd/yyyy)		

II. Current Insurance Plan Information (Please attach a copy of your member ID card and a billing statement)

Does the applicant currently have health insurance? ☐ Yes ☐ No If no, number of months without health insurance? _____
Is the applicant a citizen or legal resident of the U.S.? ☐ Yes ☐ No

Plan Name (See member ID card)	Member ID Number	Policy Number
Payee Name	Premium Amount \$ Monthly	Payee's Federal Tax ID Number
Payee Address (Number, Street, or P.O. Box)	City	State Zip Code



2. Diagnosis Form

State of California - Health and Human Services Agency		California Department of Public Health	
DIAGNOSIS FORM			
This form must be completed and signed by a physician or a licensed health care provider.			
I. Patient Information			
Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy) / /	
Does this patient have HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No			
II. Physician Information			
Physician Name:			
Address (Number, Street, Suite #)		City	Zip Code
Telephone Number		Fax Number	
Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS).			
I certify that the information provided on this form is true and correct to the best of my knowledge.			
_____ Licensed Health Care Provider Name (Printed)		_____ License Number	
_____ Licensed Health Care Provider (Signature)		_____ Date	



2. Diagnosis Form

- Used to verify HIV/AIDS diagnosis

This form must be completed and signed by a physician or a licensed health care provider.

I. Patient Information		
Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)
Does this patient have HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No		
II. Physician Information		
Physician Name:		
Address (Number, Street, Suite #)		City
Telephone Number		Fax Number
Zip Code		
Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Medication Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS).		
I certify that the information provided on this form is true and correct to the best of my knowledge.		
_____ Licensed Health Care Provider Name (Printed)		_____ License Number
_____ Licensed Health Care Provider (Signature)		_____ Date

- Must be signed by a licensed health care provider
 - Provider must input his/her license number



3. Financial Eligibility Form

FINANCIAL ELIGIBILITY FORM							
Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)		Mother's Maiden Name			
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Registered Domestic Partner <input type="checkbox"/> Other				Household Size (Please include applicant in this number)			
Applicants who have an adjusted gross income at or below \$50,000 need only to submit <u>their</u> income information and documentation. Applicants with income above \$50,000 must also submit their spouse's income and documentation. Income eligibility will be based on half the combined income.							
Adjusted gross income as stated on applicant's federal or state income tax return: Applicants Income _____ Spouse's Income _____ Total Adjusted Gross Income \$ _____							
Applicants without a tax return must identify all sources of income and provide the amounts from the applicant's and if applicable spouse's income documentation. If income is not reported as an annual amount, annualize the income (i.e., weekly income x 52)							
Source of Income	Please check all that apply		How much income/money is received?		How often is income/money received? (i.e., weekly, monthly)		Gross Annual Household Income
	Applicant	Spouse	Applicant	Spouse	Applicant	Spouse	
Employment							
Self-Employment							
SSI/SSA							
Social Security Disability Insurance (SSDI)							
State Disability Income (SDI)							
General Assistance/General Relief							
Private Disability							
Unemployment Insurance (UI)							
Retirement/Pension							
Worker's Compensation							
Investment or Interest Income							
Veteran's Administration (VA) Benefits							
Alimony							
Other							
						Total Gross Income	\$
Identify the income documentation provided by checking all that apply:							
<input type="checkbox"/> Federal Income Tax Return* <input type="checkbox"/> Disability Award Letter <input type="checkbox"/> Benefit Receipt or Check Stub** <input type="checkbox"/> California State Tax Return* <input type="checkbox"/> Support Verification Affidavit <input type="checkbox"/> Pay Stub** <input type="checkbox"/> W-2 or 1099 Tax Form <input type="checkbox"/> Self-Employment Affidavit <input type="checkbox"/> Bank Statement** (clearly states income source)							
* Copies of Schedule C, W-2 or 1099 tax forms must be included with tax return documents.							
** Must provide documentation for 3 current consecutive months.							
Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.							
I certify that the answers I have given in this form and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance. I also understand that CDPH/OA staff are permitted to request additional income verification if income reported appears to be inconsistent or incorrect.							
Applicant's Signature _____				Date _____			



3. Financial Eligibility Form

- If client earns *less* than \$50,000...
 - ...only submit **client** income information and documentation

Applicants who have an adjusted gross income at or below \$50,000 need only to submit <u>their</u> income information and documentation. Applicants with income above \$50,000 must also submit their spouse's income and documentation. Income eligibility will be based on half the combined income.				
Adjusted gross income as stated on applicant's federal or state income tax return: Applicants Income _____ Spouse's Income _____ Total Adjusted Gross Income \$ _____				
Applicants without a tax return must identify all sources of income and provide the amounts from the applicant's and if applicable spouse's income documentation. If income is not reported as an annual amount, annualize the income (i.e., weekly income x 52)				
Source of Income	Please check all	How much	How often is	Gross Annual

- If client earns *more* than \$50,000
 - ...must **include** spouse's or registered domestic partner's income as well if applicable
 - Eligibility will be based on ***half the combined income***



- | Applicants without a tax return must identify all sources of income and provide the amounts from the applicant's and if applicable spouse's income documentation. If income is not reported as an annual amount, annualize the income (i.e., weekly income x 52) | | | | | | | |
|--|-----------------------------|--------|------------------------------------|--------|--|--------|-------------------------------|
| Source of Income | Please check all that apply | | How much income/money is received? | | How often is income/money received?
(i.e., weekly, monthly) | | Gross Annual Household Income |
| | Applicant | Spouse | Applicant | Spouse | Applicant | Spouse | |
| Employment | | | | | | | |
| Self-Employment | | | | | | | |
| SSI/SSA | | | | | | | |
| Social Security Disability Insurance (SSDI) | | | | | | | |
| State Disability Income (SDI) | | | | | | | |
| General Assistance/General Relief | | | | | | | |
| Private Disability | | | | | | | |
| Unemployment Insurance (UI) | | | | | | | |
| Retirement/Pension | | | | | | | |
| Worker's Compensation | | | | | | | |
| Investment or Interest Income | | | | | | | |
| Veteran's Administration (VA) Benefits | | | | | | | |
| Alimony | | | | | | | |
| Other | | | | | | | |
| | Total Gross Income | | | | | | \$ |



3. Financial Eligibility Form

- Must provide:
 - Supporting documentation for **each** income source.



Identify the income documentation provided by checking all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Federal Income Tax Return* | <input type="checkbox"/> Disability Award Letter | <input type="checkbox"/> Benefit Receipt or Check Stub** |
| <input type="checkbox"/> California State Tax Return* | <input type="checkbox"/> Support Verification Affidavit | <input type="checkbox"/> Pay Stub** |
| <input type="checkbox"/> W-2 or 1099 Tax Form | <input type="checkbox"/> Self-Employment Affidavit | <input type="checkbox"/> Bank Statement** (clearly states income source) |

* Copies of Schedule C, W-2 or 1099 tax forms must be included with tax return documents.

** Must provide documentation for 3 current consecutive months.

~~Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.~~

I certify that the answers I have given in this form and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance. I also understand that CDPH/OA staff are permitted to request additional income verification if income reported appears to be inconsistent or incorrect.

Applicant's Signature

Date



4. Support Verification Affidavit

SUPPORT VERIFICATION AFFIDAVIT				
<p>The following information is required for applicants who are being supported by another individual/agency, or who are homeless and unable to provide proof of income or residency.</p>				
I. Applicant Information				
Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)		Mother's Maiden Name
Home Address (Number, Street, Apt #)		City	County	State Zip Code
Mailing Address (if different than home)		City	County	State Zip Code
Telephone Number (Home):		Telephone Number (Alternate):		
<input type="checkbox"/> Check here if currently homeless				
<p>The following information is to be completed by any individual who is providing support to the applicant.</p>				
II. Support Information				
The applicant named above receives the following from me:				
<input type="checkbox"/> Housing <input type="checkbox"/> Utilities <input type="checkbox"/> Food <input type="checkbox"/> Cash				
I expect to continue to provide these items until:				
My relationship to the person named above is:				
<p>Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS).</p>				
I certify that the information provided on this form is true and correct to the best of my knowledge.				
<p>_____ Printed Support Provider's Name</p>				
<p>_____ Signature of Support Provider _____ Date</p>				
<p>The following section is to be completed by the agency representative of an agency that provides support and who is able to verify the client's living situation</p>				
The above named person receives the following services from this agency:				
<input type="checkbox"/> Shelter <input type="checkbox"/> Social services <input type="checkbox"/> Other _____				
I certify that the above named person is (check all that apply) : <input type="checkbox"/> Homeless with no source of income, <input type="checkbox"/> Homeless, but a resident of California, <input type="checkbox"/> Other _____				
Agency Name		Agency Representative		
Agency Address (Number, Street, Suite #)		City	State	Zip Code
Agency Telephone Number		Agency Fax Number		



4. Support Verification Affidavit

- Must be submitted by clients who receive financial assistance or are homeless

The following information is required for applicants who are being supported by another individual/agency, or who are homeless and unable to provide proof of income or residency.

I. Applicant Information	
Applicant's Name (First, MI, Last)	
Date of Birth (mm/dd/yyyy)	
Mother's Maiden Name	
Home Address (Number, Street, Apt #)	City
County	State
Zip Code	
Mailing Address (if different than home)	City
County	State
Zip Code	
Telephone Number (Home):	Telephone Number (Alternate):
<input type="checkbox"/> Check here if currently homeless	
The following information is to be completed by any individual who is providing support to the applicant.	
II. Support Information	
The applicant named above receives the following from me:	
<input type="checkbox"/> Housing <input type="checkbox"/> Utilities <input type="checkbox"/> Food <input type="checkbox"/> Cash	
I expect to continue to provide these items until:	
My relationship to the person named above is:	
Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS).	
I certify that the information provided on this form is true and correct to the best of my knowledge.	
Printed Support Provider's Name	
Signature of Support Provider	Date



4. Support Verification Affidavit

Section I

- **Client** must complete



Section II

- **Client's support entity** must complete
 - Individual/homeless shelter representative



Section III

- **You** must complete



State of California – Health and Human Services Agency
California Department of Public Health

SUPPORT VERIFICATION AFFIDAVIT

The following information is required for applicants who are being supported by another individual/agency, or who are homeless and unable to provide proof of income or residency.

I. Applicant Information				
Applicant's Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)		Mother's Maiden Name
Home Address (Number, Street, Apt #)	City	County	State	Zip Code
Mailing Address (if different than home)	City	County	State	Zip Code
Telephone Number (Home):		Telephone Number (Alternate):		
<input type="checkbox"/> Check here if currently homeless				

The following information is to be completed by any individual who is providing support to the applicant.

II. Support Information				
The applicant named above receives the following from me:				
<input type="checkbox"/> Housing	<input type="checkbox"/> Utilities	<input type="checkbox"/> Food	<input type="checkbox"/> Cash	
I expect to continue to provide these items until:				
My relationship to the person named above is:				
Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS).				
I certify that the information provided on this form is true and correct to the best of my knowledge.				
Printed Support Provider's Name				
Signature of Support Provider		Date		

The following section is to be completed by the agency representative of an agency that provides support and who is able to verify the client's living situation

The above named person receives the following services from this agency:				
<input type="checkbox"/> Shelter	<input type="checkbox"/> Social services	<input type="checkbox"/> Other		
I certify that the above named person is (check all that apply) : <input type="checkbox"/> Homeless with no source of income, <input type="checkbox"/> Homeless, but a resident of California, <input type="checkbox"/> Other				
Agency Name		Agency Representative		
Agency Address (Number, Street, Suite #)	City	State	Zip Code	
Agency Telephone Number	Agency Fax Number			



5. Self-Employment Affidavit

State of California – Health and Human Services Agency		California Department of Public Health
SELF-EMPLOYMENT AFFIDAVIT		
This form is to be completed by self-employed applicants who are unable to provide tax records and/or pay stubs to establish annual income.		
Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy) / /	Mother's Maiden Name
I am self-employed. I have listed my total earnings for the past three months from _____ to the present as follows: Month/Year		
Month/Year	Type of Work	Monthly Income \$
Month/Year	Type of Work	Monthly Income \$
Month/Year	Type of Work	Monthly Income \$
Total (sum of the three months listed) \$		Estimated Total Gross Income (multiply total by four) \$
Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.		
I certify that the information on this form is true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance. Furthermore, I agree to immediately notify the Insurance Assistance Section of any changes in my annual income.		
Applicant's Signature		Date



5. Self-Employment Affidavit

- Must be completed by clients who are self-employed and are unable to provide pay stubs or tax records.

State of California – Health and Human Services Agency California Department of Public Health

SELF-EMPLOYMENT AFFIDAVIT

This form is to be completed by self-employed applicants who are unable to provide tax records and/or pay stubs to establish annual income.

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name
/ /		

I am self-employed. I have listed my total earnings for the past three months from _____ to the present as follows: Month/Year

Month/Year	Type of Work	Monthly Income \$
Month/Year	Type of Work	Monthly Income \$
Month/Year	Type of Work	Monthly Income \$
Total (sum of the three months listed) \$		Estimated Total Gross Income (multiply total by four) \$

Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.

I certify that the information on this form is true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance. Furthermore, I agree to immediately notify the Insurance Assistance Section of any changes in my annual income.

Applicant's Signature	Date
-----------------------	------



6. Public Assistance Screening Form

State of California – Health and Human Services Agency		California Department of Public Health
PUBLIC ASSISTANCE SCREENING FORM		
Please print clearly and answer all questions. Failure to provide complete information may delay processing of your application and receiving insurance premium assistance.		
Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy) / /	Mother's Maiden Name
I. Medi-Cal Screening		
Does applicant currently receive Medi-Cal: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has applicant recently applied for Medi-Cal: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date: Type of proof attached: <input type="checkbox"/> Denied <input type="checkbox"/> Pending		
Was applicant referred to apply: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, referral date:		
If not referred to apply for Medi-Cal, select the specific reason and indicate the documentation provided to support the Medi-Cal non-referral reason: <input type="checkbox"/> Disability Denial <input type="checkbox"/> Excess Assets <input type="checkbox"/> Employed <input type="checkbox"/> Receiving Unemployment <input type="checkbox"/> Ineligible Immigrant Medi-Cal non-referral proof: <input type="checkbox"/> Medi-Cal, SSI, SSDI disability denial letter <input type="checkbox"/> Excess assets documentation <input type="checkbox"/> Employment income documentation <input type="checkbox"/> Unemployment insurance documentation <input type="checkbox"/> Other		
II. Medicare Screening		
Does applicant currently receive Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Will the applicant qualify for Medicare in the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the applicant currently receiving income from Social Security Disability Insurance (SSDI)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
III. Veteran's Administration (VA) Screening		
Is applicant eligible for Veteran's Administration (VA) health care benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Is applicant able to access health care services and prescription medications through the VA system? <input type="checkbox"/> Yes <input type="checkbox"/> No If no explain here:		
Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.		
I certify that the information on this form is true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance.		
Applicant's Signature		Date



6. Public Assistance Screening Form

Purposes of Form

- Clients ***must apply*** for public health assistance if they are eligible
- The Office of AIDS ***must ensure*** that it is the payer of last resort.

State of California – Health and Human Services Agency
California Department of Public Health

PUBLIC ASSISTANCE SCREENING FORM

Please print clearly and answer all questions. Failure to provide complete information may delay processing of your application and receiving insurance premium assistance.

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy) / /	Mother's Maiden Name
------------------------------------	-----------------------------------	----------------------

I. Medi-Cal Screening

Does applicant currently receive Medi-Cal: ☐ Yes ☐ No

Has applicant recently applied for Medi-Cal: ☐ Yes ☐ No If yes, Date: _____
Type of proof attached: Status: ☐ Denied ☐ Pending

Was applicant referred to apply: ☐ Yes ☐ No If yes, referral date: _____

If not referred to apply for Medi-Cal, select the specific reason and indicate the documentation provided to support the Medi-Cal non-referral reason:
☐ Disability Denial ☐ Excess Assets ☐ Employed ☐ Receiving Unemployment ☐ Ineligible Immigrant
Medi-Cal non-referral proof:
☐ Medi-Cal, SSI, SSDI disability denial letter ☐ Excess assets documentation
☐ Employment income documentation ☐ Unemployment insurance documentation ☐ Other

II. Medicare Screening

Does applicant currently receive Medicare?
☐ Yes ☐ No

Will the applicant qualify for Medicare in the next 12 months?
☐ Yes ☐ No

Is the applicant currently receiving income from Social Security Disability Insurance (SSDI)?
☐ Yes ☐ No

III. Veteran's Administration (VA) Screening

Is applicant eligible for Veteran's Administration (VA) health care benefits?
☐ Yes ☐ No

Is applicant able to access health care services and prescription medications through the VA system?
☐ Yes ☐ No If no explain here: _____

Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.

I certify that the information on this form is true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance.

Applicant's Signature

Date



6. Public Assistance Screening Form

- Client must submit
 - Proof they applied for ***Medi-Cal*** within 30 days of submitting application
 - Medi-Cal determination documents within 150 days of submitting application
- Enrolled Medicare clients ***are not eligible*** for OA-HIPP

State of California – Health and Human Services Agency
California Department of Public Health

PUBLIC ASSISTANCE SCREENING FORM

Please print clearly and answer all questions. Failure to provide complete information may delay processing of your application and receiving insurance premium assistance.

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name
------------------------------------	----------------------------	----------------------

I. Medi-Cal Screening

Does applicant currently receive Medi-Cal: ☐ Yes ☐ No

Has applicant recently applied for Medi-Cal: ☐ Yes ☐ No If yes, Date: _____
Type of proof attached: _____ Status: ☐ Denied ☐ Pending

Was applicant referred to apply: ☐ Yes ☐ No If yes, referral date: _____

If not referred to apply for Medi-Cal, select the specific reason and indicate the documentation provided to support the Medi-Cal non-referral reason:

☐ Disability Denial ☐ Excess Assets ☐ Employed ☐ Receiving Unemployment ☐ Ineligible Immigrant
☐ Medi-Cal, SSI, SSDI disability denial letter ☐ Excess assets documentation
☐ Employment income documentation ☐ Unemployment insurance documentation ☐ Other

II. Medicare Screening

Does applicant currently receive Medicare?

☐ Yes ☐ No

Will the applicant qualify for Medicare in the next 12 months?

☐ Yes ☐ No

Is the applicant currently receiving income from Social Security Disability Insurance (SSDI)?

☐ Yes ☐ No

III. Veteran's Administration (VA) Screening

Is applicant eligible for Veteran's Administration (VA) health care benefits?

☐ Yes ☐ No

Is applicant able to access health care services and prescription medications through the VA system?

☐ Yes ☐ No If no explain here: _____

Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section.

I certify that the information on this form is true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance.

Applicant's Signature

Date



7. Insurance Assistance Consent Form

INSURANCE ASSISTANCE SECTION CONSENT FORM

Consent to Participate and Consent to Release Personal and Medical Information Client Eligibility

Insurance Assistance Section (IAS) is administered by the California Department of Public Health (CDPH), Office of AIDS (OA) to provide health insurance premium payment assistance to low-income individuals living with human immunodeficiency virus (HIV). Individuals applying for IAS services must meet eligibility standards. Services are only available to individuals living with HIV/AIDS who reside in California, are at least 18 years old, and have a federal adjusted gross income below \$50,000. To verify eligibility for this program, CDPH, or its agents may be required to obtain personal information from other agencies or health care providers. If you agree to take part in IAS, the enrolling agency will collect personal information including your name, date of birth, address, Social Security Number, medical history, and financial eligibility for the program. The information will be considered confidential, but may be released to health care providers, and CDPH staff, for the sole purpose of administering the program. Information that you provide for your application may be made available to your local health department for statistical and research purposes. This information includes, but is not limited to, gender, ethnicity, zip code, diagnosis status, and date of birth. This information may also be used for research and professional writings under strict assurances that all identifying information including name and Social Security Number is deleted. Any professional or research reports that may be published will not use your name nor any personal identifying information. Confidentiality agreements are in place, which keep client information confidential except with specific client consent or as otherwise allowed by law.

I, _____, consent to release of personal and medical information as described above to CDPH, other health care professionals who provide services to me, and other governmental or public agencies as necessary to determine my eligibility for IAS services. This consent shall remain in effect for two years from the date of my signature below unless revoked by me in writing. A photocopy of the authorization shall be considered as valid as the original. All laws regarding confidentiality of any and all information provided shall be strictly adhered at all times. Any disclosure authorized by the consent form shall be made only upon agreement that the information will be kept confidential.

Applicant's Signature _____

Date _____

Enrollment Worker's Name _____

Date _____

Enrollment Worker's Signature _____

Date _____

Agency Name

Agency Representative

Agency Telephone Number

Agency Address (Number, Street, Suite #)

City

State

Zip Code



7. Insurance Assistance Consent Form

- Allows CDPH to release client demographic information for administrative and/or research related purposes.
- Must be signed by the client *and* Enrollment Worker

**INSURANCE ASSISTANCE SECTION
CONSENT FORM**

Consent to Participate and Consent to Release Personal and Medical Information Client Eligibility

Insurance Assistance Section (IAS) is administered by the California Department of Public Health Office of AIDS (OA) to provide health insurance premium payment assistance to low-income individuals living with human immunodeficiency virus (HIV). Individuals applying for IAS services must meet the following standards. Services are only available to individuals living with HIV/AIDS who reside in California, are at least 18 years old, and have a federal adjusted gross income below \$50,000. To verify eligibility, the program, CDPH, or its agents may be required to obtain personal information from other agencies, including health care providers. If you agree to take part in IAS, the enrolling agency will collect personal information including your name, date of birth, address, Social Security Number, medical history, and other information necessary to determine your eligibility for the program. The information will be considered confidential, but may be released to health care providers, and CDPH staff, for the sole purpose of administering the program. Information you provide for your application may be made available to your local health department for statistical and research purposes. This information includes, but is not limited to, gender, ethnicity, zip code, date of birth, and date of birth. This information may also be used for research and professional purposes under strict assurances that all identifying information including name and Social Security Number will be deleted. Any professional or research reports that may be published will not use your name nor any personal identifying information. Confidentiality agreements are in place, which keep client information confidential except with specific client consent or as otherwise allowed by law.

I, _____, consent to release of personal and medical information as described above to CDPH, other health care professionals who provide services to me, and other governmental or public agencies as necessary to determine my eligibility for IAS services. This consent shall remain in effect for two years from the date of my signature below unless revoked by me in writing. A photocopy of the authorization shall be considered as valid as the original. All laws regarding confidentiality of any and all information provided shall be strictly adhered at all times. Any disclosure authorized by the consent form shall be made only upon agreement that the information will be kept confidential.

Applicant's Signature _____ Date _____

Enrollment Worker's Name _____ Date _____

Enrollment Worker's Signature _____ Date _____

Agency Name _____ Agency Representative _____ Agency Telephone Number _____

Agency Address (Number, Street, Suite #) _____ City _____ State _____ Zip Code _____



8. Client Report Form

CLIENT REPORT FORM		
Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy) / /	Mother's Maiden Name
Race/Ethnicity (Check all that apply): <input type="checkbox"/> White, non-Hispanic <input type="checkbox"/> African American (non-Hispanic) <input type="checkbox"/> African American/Black <input type="checkbox"/> Caribbean, not Puerto Rican or Cuban <input type="checkbox"/> African/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> East Asian <input type="checkbox"/> South Asian <input type="checkbox"/> Southeast Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____ <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Mexican/Mexican American <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Central American <input type="checkbox"/> South American <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> American Indian, Aleutian, Native Alaskan, Eskimo <input type="checkbox"/> Unknown or declined		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Other _____ <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Declined		
HIV Diagnosis: <input type="checkbox"/> HIV <input type="checkbox"/> AIDS <input type="checkbox"/> Disabled due to HIV/AIDS <input type="checkbox"/> Disabled due to _____ <input type="checkbox"/> Not Disabled		
Income: Household Monthly Income _____ Number of Persons in Household _____		
Receiving Public Assistance (other than Medi-Cal): <input type="checkbox"/> SSI <input type="checkbox"/> SDI <input type="checkbox"/> SSDI <input type="checkbox"/> General Assistance <input type="checkbox"/> Other _____		
<p>■ Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS).</p> <p>■ All client-level data for Ryan White Program services managed through the California Department of Public Health, Office of AIDS (OA) are entered into the AIDS Regional Information and Evaluation System (ARIES). ARIES is a highly secure, confidential, customized, Web-based, centralized client management system that provides a single point of entry for clients and allows for coordination of client services among providers. ARIES is intended to enhance services to clients by helping providers automate, plan, manage, and report on client services. At provider sites, clients sign an ARIES consent form choosing whether or not to share their information with other agencies they seek services from; this "sharing" allows clients to receive services from additional ARIES providers without having to carry a copy of their doctor's letter, proof of income, and/or living situation to each agency. ARIES is designed to save time for the clients and help ensure quick access to needed services.</p> <p>If a person ONLY receives health insurance premium assistance through the Insurance Assistance Program, then their personal information in ARIES will NOT be shared with any other ARIES providers. However, should an approved IAS client visit another ARIES provider, the client will sign an ARIES consent form at that agency and choose whether or not to share their ARIES data.</p> <p>■ If a person is receiving care services other than health insurance premium assistance and is already entered into ARIES as a "share client" at the time of their health insurance premium assistance enrollment, their share status will remain as "share" and not be changed to "non-share."</p> <p>■ I understand that as a condition of receiving services, I consent that my ARIES information may be made available to my local health department, to local fiscal agents who fund the services I receive, and to OA for mandated care and treatment reporting, program monitoring, statistical analysis, and research activities. This data includes, but is not limited to, demographic, financial, and service information.</p> <p>■ I understand that this consent remains in effect for three (3) years from the date I sign this form, unless I change my share status before that date by signing a new ARIES Consent Share/Non-share Consent Form.</p> <p>■ I certify that the answers I have given in this form are true and correct to the best of my knowledge.</p>		
Applicant's Signature _____		Date _____



8. Client Report Form

- Allows CDPH to collect client demographic information

- Gender
- Household Income
- HIV Diagnosis
- Public Assistance

- Must be signed by applicant

State of California - Health and Human Services Agency
California Department of Public Health

CLIENT REPORT FORM

Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Mother's Maiden Name
Race/Ethnicity (Check all that apply): <input type="checkbox"/> White, non-Hispanic <input type="checkbox"/> African American (non-Hispanic) <input type="checkbox"/> African American/Black <input type="checkbox"/> Caribbean, not Puerto Rican or Cuban <input type="checkbox"/> African/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> East Asian <input type="checkbox"/> South Asian <input type="checkbox"/> Southeast Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____ <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Mexican/Mexican American <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Central American <input type="checkbox"/> South American <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> American Indian, Aleutian, Native Alaskan, Eskimo <input type="checkbox"/> Unknown or declined		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Other _____ <input type="checkbox"/> Declined		
HIV Diagnosis: <input type="checkbox"/> HIV <input type="checkbox"/> AIDS <input type="checkbox"/> Disabled due to HIV/AIDS <input type="checkbox"/> Disabled due to _____ <input type="checkbox"/> Not Disabled		
Income: Household Monthly Income _____ Number of Persons in Household _____		
Receiving Public Assistance (other than Medi-Cal): <input type="checkbox"/> SSI <input type="checkbox"/> SDI <input type="checkbox"/> SSDI <input type="checkbox"/> General Assistance <input type="checkbox"/> Other _____		
<p>■ Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2009 and is required by the California Department of Public Health (CDPH), Office of AIDS (OA), Insurance Assistance Section (IAS).</p> <p>■ All client-level data for Ryan White Program services managed through the California Department of Public Health, Office of AIDS (OA) are entered into the AIDS Regional Information and Evaluation System (ARIES). ARIES is a highly secure, confidential, customized, Web-based, centralized client management system that provides a single point of entry for clients and allows for coordination of client services among providers. ARIES is intended to enhance services to clients by helping providers automate, plan, manage, and report on client services. At provider sites, clients sign an ARIES consent form choosing whether or not to share their information with other agencies they seek services from; this "sharing" allows clients to receive services from additional ARIES providers without having to carry a copy of their doctor's letter, proof of income, and/or living situation to each agency. ARIES is designed to save time for the clients and help ensure quick access to needed services.</p> <p>If a person ONLY receives health insurance premium assistance through the Insurance Assistance Program, then their personal information in ARIES will NOT be shared with any other ARIES providers. However, should an approved IAS client visit another ARIES provider, the client will sign an ARIES consent form at that agency and choose whether or not to share their ARIES data.</p> <p>■ If a person is receiving care services other than health insurance premium assistance and is already entered into ARIES as a "share client" at the time of their health insurance premium assistance enrollment, their share status will remain as "share" and not be changed to "non-share."</p> <p>■ I understand that as a condition of receiving services, I consent that my ARIES information may be made available to my local health department, to local fiscal agents who fund the services I receive, and to OA for mandated care and treatment reporting, program monitoring, statistical analysis, and research activities. This data includes, but is not limited to, demographic, financial, and service information.</p> <p>■ I understand that this consent remains in effect for three (3) years from the date I sign this form, unless I change my share status before that date by signing a new ARIES Consent Share/Non-share Consent Form.</p> <p>■ I certify that the answers I have given in this form are true and correct to the best of my knowledge.</p>		
Applicant's Signature _____	Date _____	

Questions





Our Path Today



1. OA-HIPP
2. Application Processing
3. Enrollment





Application Processing

- Complete vs. incomplete



- Approved vs. denied





Contact Information

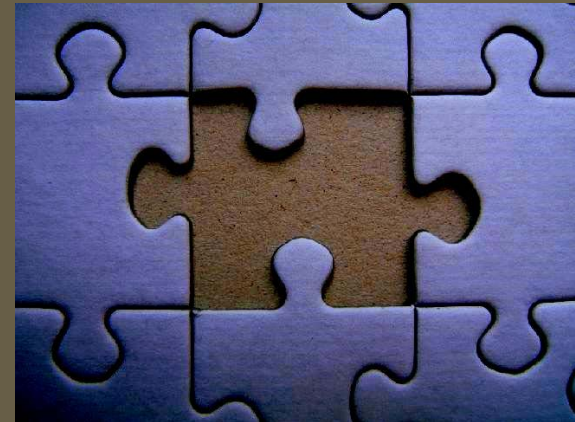
- Direct all inquiries to ias@cdph.ca.gov *and* to your analyst
- Analysts are assigned to clients by client's last name.
 - A-L
 - Jim Sviben: jim.sviben@cdph.ca.gov
 - M-O
 - Benita White: benita.white@cdph.ca.gov
 - P-Q
 - Jill Young: jill.young@cdph.ca.gov
 - R-S, PRC
 - Kathy Whitaker: kathy.whitaker@cdph.ca.gov
 - T-Z
 - Justine Blanco: justine.blanco@cdph.ca.gov
 - Or fax to (916) 449-5860.





Incomplete Applications

- You should ensure that all forms have been filled out correctly and include ***all*** supporting documentation ***before*** sending to OA
- If application packet is incomplete, the assigned analyst will contact and work with you to resolve the issue
- Incomplete applications ***may delay*** the client's approval





Approved Applications

- Letter is sent to you *and* the health insurance provider stating that the client has been approved for OA-HIPP.
- Quarterly payment is sent to provider with the letter.
- Retroactive payment up to four months is available!!!





Denied Applications

- A letter explaining the reason for OA-HIPP denial is *immediately* sent to you.
- Client may be eligible for OA-PCIP





Centralized Enrollment

- The preferred mechanism for enrollment into OA-HIPP is through the enrollment worker
- Clients can apply directly to OA
- Applications are available for download at www.cdph.ca.gov/programs/aids.....
- Clients can also call the OA hotline at 800.367.2467 for technical assistance
- Assigned OA analyst will function as an Enrollment Worker and help the client enroll





New Enrollment Site

- If you would like to become an OA-HIPP enrollment site, simply:
 - Email Richard Martin at richard.martin@cdph.ca.gov or call 916.449.5974
 - Submit a Payee Data Record (provided by Richard)
 - Ensure that all staff who will be enrolling clients into OA-HIPP complete this training





MEARI Payments

- **Month End Agency Reimbursement Invoices:**
 - \$25 Incentive paid **biannually** to Enrollment Sites
 - For processing initial OA-HIPP **applications**
 - For processing **recertifications**
 - Incentive paid for **each** client application or recertification





New Enrollment Workers

- To become an OA-HIPP Enrollment Worker:
 - Complete this training
 - Complete anonymous survey at:
<http://www.surveymonkey.com/s/LVCRCVG>
 - Provide personal contact information through second survey monkey link at:
<http://www.surveymonkey.com/s/BSBR2GS>
 - After your contact information is received, you will be sent a short quiz and Confidentially Agreement by Jill Young.
 - Send completed quiz and signed Confidentiality Agreement to Jill.
- Jill can be reached at jill.young@cdph.ca.gov or 916.449.5952 for technical assistance.
- Annual Recertification required

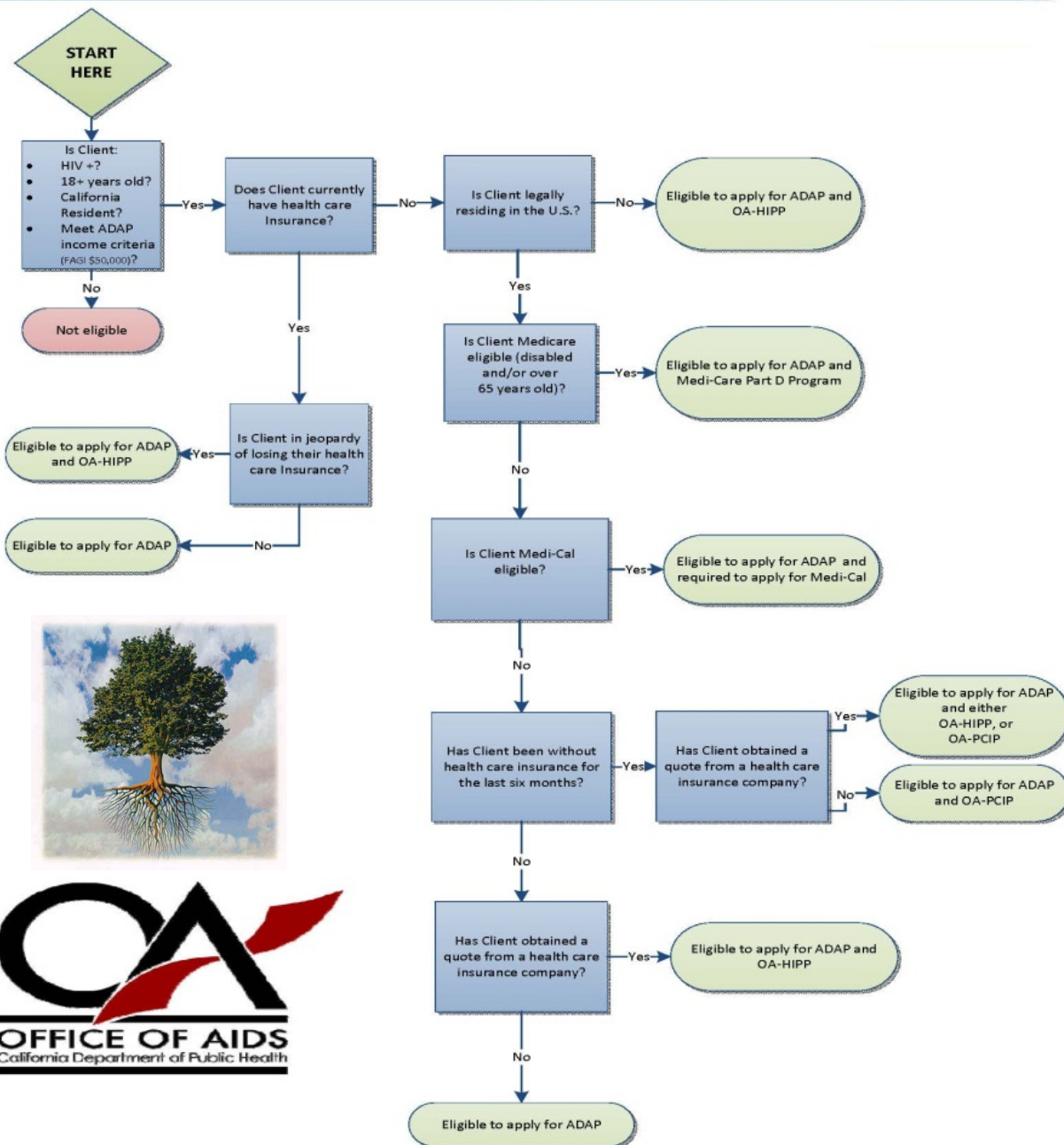




Decision Tree

- Tool to help you determine what program(s) client may be eligible for
- Included with applications and program guidance





questions
anyone?





PCIP Training

- OA-PCIP Enrollment Worker Training Sessions will be conducted via webinar on August 2, 3 & 11



